(b) Total charges for inpatient services for charity care (less cash subsidies above, and not including contractual allowances and discounts other than for indigent patients ineligible for Medicaid) divided by the total charges for inpatient services.

(3) A Medicaid inpatient utilization rate greater than or equal to one percent.

C. Determination of hospital disproportionate share groups for payment distribution

Hospitals determined to be disproportionate share as described above will be classified into one of four tiers for payment distribution based on the data described in paragraph a above. The tiers are described below:

(1) Tier one includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate grater than 25% but less than 40%, or deemed a disproportionate share hospital based on a Medicaid inpatient utilization rate that is one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.

(2) Tier two includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 40% but less than 50%.

(3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 50% but less than 60%.

(4) Tier four includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 60% .

D. Distribution of funds within each hospital tier

The funds available in a tier are distributed among hospitals in that tier according to the payment formulas described below. Hospitals will be distributed a payment amount based on the lesser of their uncompensated care costs or their disproportionate share payment. Uncompensated care costs are defined as total inpatient allowable costs less insurance revenues, self-pay revenues, total Medicaid revenues and uncompensated care costs rendered to patients with insurance for the service provided. Each hospital's disproportionate share payment is calculated on a tier-specific basis as follows:

$$\frac{\text{Hospital specific uncompensated care Costs}}{\text{sum of uncompensated care costs for all hospitals in the tier}} \times \text{Disproportionate share funds available for distribution in the tier}$$

(1) Funds available for distribution by tier.

(a) Tier 1. A maximum of 5% of the disproportionate share funds will be distributed to the hospitals in tier one.

If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds from tier one will be added to the funds available for distribution in tier four.

(b) Tier 2. A maximum of **25%** of the disproportionate share funds will be distributed to hospitals in tier two.

If no hospitals fall into tier two, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.

(c) Tier 3. A maximum of 45% of the disproportionate share funds will be distributed to hospitals in tier three.

If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.

(d) Tier 4. A minimum of 40% of the disproportionate share funds will be distributed to hospitals in tier four.

(2) Payment distribution

Each hospital will be distributed a payment amount based on the lesser of their:

(a) Uncompensated care costs; or

(b) Disproportionate share payment amount

E. Disproportionate share funds

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5101:3-2-09 of the administrative code from the state's disproportionate share limit as described in subparagraph (f) of section 1923 of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396-r-4 (f), as amended.

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5101:3-2-09 of the administrative code from the state's disproportionate share limit as described in subparagraph (f)(2)(a) of section 1923 of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396-r-4 (f)(2), as amended.

5101:3-1-07 General fiscal policies.

(A) Submission of invoices--The original copy of the particular provider's invoice should be submitted to the department as soon as possible after the service is provided, but at least monthly. In no case will payment be made for services rendered one year or more prior to receipt of the invoice. The carbon copy of the invoice should be retained by the provider as a record of the claim submitted. The "date of receipt" is the date the department receives the claim, as indicated by the Julian date within the transaction control number assigned by the department.

(B) The department sends a "Remittance Statement" upon payment of the provider's invoice which identifies what service is being paid for, and for which recipient. The information printed on the statement is self-explanatory except for the transaction control number. The "transaction control number" is a number assigned by the department to each claim received that uniquely identifies that claim. When making inquiry of the department concerning a claim payment, the transaction control number for that claim is to be furnished.

(C) Typing of invoices is required on some of the department's invoices - particularly those called optical character reader (OCR). "OCR" is a system whereby the billing information is transmitted directly to the computer resulting in faster payment to the provider.

(D) The "Current Procedural Terminology" (CPT) is used to codify medical procedures and services rendered to a patient by a physician or therapist. (Note: Other ~~providers~~ PRACTITIONERS, such as dentists, are supplied with specific codes.) Each procedure or service is identified with a five-digit code. The modifiers listed in the CPT code book do not apply under Ohio's medicaid program. The department has instituted numerous additions and deletions to the CPT codes which are contained in ~~"Appendix B."~~ RULE 5101:3-1-60 OF THE ADMINISTRATIVE CODE.

(E) The "International Classification of Diseases" (ICD) is for use in coding the diagnosis or nature of the injury of the patient AND PROCEDURES ASSOCIATED WITH SERVICES. HOSPITALS ARE TO REPORT BOTH DIAGNOSES AND PROCEDURES ACCORDING TO ICD WHEN BILLING FOR INPATIENT AND OUTPATIENT SERVICES.

(F) Method of payment--All payment is by warrant, based on information supplied by the ~~Ohio department of public welfare~~ PROVIDER and paid directly to the provider of the medical services. Federal regulations prohibit the payment for medical services to the recipient of that service. The provider, therefore, must submit invoices on prescribed forms for medical services to the Ohio department of ~~public welfare~~ HUMAN SERVICES for payment.

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(G) Mailing of payment warrant--Payment of invoices correctly submitted will be mailed to the name and address associated with each respective provider number as maintained in the department's provider master file. Any changes in a provider's status, address, licensing, certification, board specialties, corporate name, or ownership must be reported immediately to the provider enrollment unit.

The mailing of payment warrants and remittance statements (the explanation of the payment) is a routine process. The department cannot honor requests for pulling a particular warrant for purposes of early mailing or personal pickup. Remittance statements are frequently mailed separately from the payment warrants.

(H) Procedure for adjusting an improper payment.

(1) If an error has been made in the payment either by the provider or the department, it must be corrected by advising the Ohio department of ~~public welfare~~ HUMAN SERVICES of the nature of the error in the following manner:

(a) Circle the line in error on a copy of the remittance statement.

(b) Do not file a corrected billing. Explain the error on the bottom of a copy of the remittance statement. For example:

(i) Duplicate payment

(ii) Overpayment

(iii) Underpayment

(iv) Third-party payment (indicate type of policy, policy number, amount paid, and the company name and address)

(v) Miscellaneous (explain)

(2) Adjustments for an overpayment, a duplicate payment, or payments for services not rendered may be made through a credit against future payment or by remitting a check, payable to the Ohio department of ~~public welfare~~ HUMAN SERVICES, for the payment amount with the above described documentation attached.

(3) If the total payment is in error, ~~please~~ return the warrant and the remittance statement TO THE DEPARTMENT. If only individual line items are in error, ~~please~~ follow the ~~above~~ instructions IN PARAGRAPHS (H)(1) TO (H)(4) OF THIS RULE and return only a copy of the remittance statement to the ~~address below~~ DEPARTMENT. Wherever practical, adjustments for improper payments for individual line items will be made on subsequent payments.

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(4) All inquiries concerning an adjustment should be directed in writing to~~:~~ THE DEPARTMENT.

~~"Ohio Department of Public Welfare~~
~~Adjustment Unit~~
~~30 East Broad Street, 37th Floor~~
~~Columbus, Ohio 43215"~~

(I) Inquiries regarding status of bills--Inquiries regarding status of claims must be subsequent to the original billing date or the date on which the claim was resubmitted to the department by at least ninety days. Such inquiries must include a legible photocopy of the original invoice and be directed to~~:~~ THE DEPARTMENT.

~~"Provider Assistance~~
~~Ohio Department of Public Welfare~~
~~P.O. Box 1461~~
~~Columbus, Ohio 43216"~~

(1) Prior to the submission of the inquiry, be sure:

(a) That the accounts receivable have been properly reconciled using the Ohio department of ~~public welfare~~ HUMAN SERVICES remittance statements. Such records must be adjusted to reflect the amount billed which exceeded the department's maximum reimbursement limit(s).

(b) That the original invoice was submitted within one year of the date of service. FOR HOSPITALS PAID ON A PROSPECTIVE BASIS AS IDENTIFIED IN RULE 5101:3-2-071 OF THE ADMINISTRATIVE CODE, "ONE YEAR FROM THE DATE OF SERVICE" IS ONE YEAR FROM THE DATE OF DISCHARGE.

(c) That the charges were not previously rejected by the department as not payable (i.e., noncovered services, not medically necessary, etc.).

(d) That eligibility of the recipient is verified with the county ~~welfare~~ department OF HUMAN SERVICES if the claim was previously rejected as "recipient ineligible."

(2) All inquiries must include a cover letter which specifies:

(a) Reason for inquiry.

(b) Name, address, provider number, and telephone number of the inquirer.

(J) Prohibition against factoring--No payment for care or services will be made to any organization or individual who is a factor.

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"Factor" is defined as an organization (collection agency, service bureau, etc.) or an individual (including those who have power of attorney) who advances money to a provider for his accounts receivable which have been assigned, sold, or otherwise transferred to such an organization or individual for an added fee or a deduction of a portion of such accounts receivable.

A factor is not a billing agent or accounting firm which prepares invoices or receives payments on behalf of the provider provided that the compensation received by the billing agent or accounting firm is on a fee-for-services basis and not on the basis of a percentage of dollar amounts billed or collected. A factor is also not the employer of a physician, dentist, or other practitioner if the practitioner is required to turn over his fees as a condition of employment, or an inpatient services facility (a hospital or nursing home) where there is a contractual agreement between the provider and facility whereby the facility submits the reimbursement claims, or an organized health care delivery system (foundation, plan, or HMO) which bills or receives payments for services performed by individuals under contractual arrangements.

(K) Recovery/audits

(1) The department's payment is payment-in-full for all services covered by the medicaid program made to eligible providers in accordance with applicable policies and procedures. Overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery except in the case of long-term care facilities as provided for in Chapter 5101:3-3 of the Administrative Code. The department may recoup such payments by an automatic adjustment on future payments.

(2) Overpayments, duplicate payments, or payments for services not rendered which are discovered during the course of a fiscal or program audit are immediately collectible except in the case of long-term care facilities as provided for in Chapter 5101:3-3 of the Administrative Code. The provider may submit a certified check in the amount of the agreed upon finding to the "Ohio Department of ~~Public Welfare~~ HUMAN SERVICES, Division of Fiscal Affiars, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43215" or the department will recoup such payments by automatic adjustment of future payments.

(3) Records necessary to fully disclose the extent of services provided must be maintained for a period of three years (or if an audit has been initiated, until the audit is completed and every exception resolved) and said records must be made available, upon request, to the department for audit purposes.

(4) No payment for outstanding medical services can be made if a request for audit is refused (see paragraph (C) of rule 5101:3-1-55 of the Administrative Code for fuller discussion).

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Providers of institutional services, limited to inpatient hospitals, INSTITUTIONAL PSYCHIATRIC FACILITIES, and nursing homes, ~~are reimbursed on a reasonable cost basis, and~~ are subject to various ADDITIONAL requirements. ~~involving cost reports, filing deadlines, settlements and audits.~~ SEE CHAPTER 5101:3-2 OF THE ADMINISTRATIVE CODE FOR REQUIREMENTS REGARDING HOSPITAL AND INSTITUTIONAL PSYCHIATRIC FACILITY SERVICES AND CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE FOR REQUIREMENTS RELATIVE TO NURSING HOMES.

~~(b) Delinquent filing of medicaid cost reports~~

~~Hospitals have one hundred eighty days from the close of their fiscal year to file a cost report with the department (see rule 5101:3-2-23 of the Administrative Code).~~

~~(1) At the beginning of the first month overdue, the department will reduce the established percentage by twenty per cent and mail a delinquency letter to inform the provider of late filing penalty procedures.~~

~~(2) At the beginning of the second, third, and fourth months respectively, the department will reduce the percentage by additional ten per cent increments for a cumulative reduction of fifty per cent.~~

~~(3) At the beginning of the fifth month overdue, termination of the provider from the programs (Title XIX, Title V, general relief) will be recommended.~~

~~(M)~~ (L) The department's payment constitutes "payment-in-full" for any covered service. The provider may not bill the recipient for any difference between that payment and the provider's charge. The provider may not charge the recipient any co-payment, cost sharing or similar charge. The provider may not charge the recipient a down payment, refundable or otherwise.

The provider may bill the recipient for any services not covered by the medicaid program, or any service requiring prior authorization which has been denied by the department, if the recipient still chooses to have those services rendered.

The fact that a claim has been returned as nonpayable due to late submission does not mean that services rendered were noncovered and therefore billable to the recipient. The recipient may not be billed for such services.

Providers, with the exception of long-term care facilities as provided for in Chapter 5101:3-3 of the Administrative Code, are not required to bill the department for medicaid covered services rendered to eligible recipients. However, providers may not bill the recipient in lieu of the department unless they so notify the recipient in advance of services being rendered and the recipient agrees to be liable for the charges.

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Certification _____

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5101:3-1-08 GENERAL FISCAL POLICY: THIRD-PARTY LIABILITY.

(A) THE OHIO MEDICAID PROGRAM CAN MAKE PAYMENT FOR COVERED SERVICES ONLY AFTER ANY AVAILABLE THIRD-PARTY BENEFITS ARE EXHAUSTED. BENEFITS AVAILABLE UNDER THE MEDICAID PROGRAM MUST BE REDUCED TO THE EXTENT THAT THEY ARE PAYABLE BY AN INSURANCE POLICY, VETERANS' COVERAGE, OR OTHER THIRD-PARTY RESOURCE. THIS PROVISION DOES NOT APPLY TO GOVERNMENTAL SUBSIDY FUNDS PAID FOR GENERAL PURPOSES, BUT DOES APPLY IF PAID FOR A SPECIFIC INDIVIDUAL.

(B) PROVIDERS ARE EXPECTED TO TAKE REASONABLE MEASURES TO ASCERTAIN ANY THIRD-PARTY RESOURCE AVAILABLE TO THE RECIPIENT AND TO FILE A CLAIM WITH THAT THIRD PARTY. IN SUCH INSTANCES, THE DEPARTMENT WILL NOT REIMBURSE FOR THE COST OF SERVICES WHICH ARE OR WOULD BE COVERED BY A THIRD-PARTY PAYOR IF BILLED TO THAT THIRD-PARTY PAYOR. FAILURE TO EXPLORE SUCH THIRD-PARTY RESOURCES WHEN KNOWN RENDERS THAT SERVICE NONREIMBURSABLE BY MEDICAID. IF THE PROVIDER RECEIVES A THIRD-PARTY PAYMENT AFTER HAVING RECEIVED A MEDICAID PROGRAM PAYMENT FOR THE SAME ITEMS AND SERVICES, THE DEPARTMENT MUST BE REIMBURSED THE OVERPAYMENT. UNDER NO CIRCUMSTANCES MAY THE PROVIDER REFUND ANY MONEY RECEIVED FROM A THIRD PARTY TO A RECIPIENT.

(1) IF THE EXISTENCE OF ANY THIRD-PARTY RESOURCE IS KNOWN TO THE DEPARTMENT, A NOTATION "PRIVATE HEALTH INSURANCE" OR "MEDICARE AND PRIVATE INSURANCE" WILL APPEAR ON THE "MEDICAL ASSISTANCE IDENTIFICATION" CARD UNDER THE RECIPIENT'S CASE NUMBER. PROVIDERS WILL THEN NEED TO OBTAIN FROM THE RECIPIENT THE NAME OF THE INSURANCE COMPANY, TYPE OF COVERAGE, AND ANY OTHER NECESSARY INFORMATION, AND BILL THE PROPER AGENCY OR INSURANCE COMPANY PRIOR TO BILLING THE DEPARTMENT. AFTER RECEIPT OF THE THIRD-PARTY RESOURCE, THE DEPARTMENT MAY BE BILLED FOR THE BALANCE. WHEN THE EXISTENCE OF THIRD-PARTY RESOURCES IS KNOWN TO THE DEPARTMENT AND A CLAIM IS SUBMITTED THAT DOES NOT INDICATE COLLECTION OF THE THIRD-PARTY PAYMENT, THE CLAIM WILL BE REJECTED PENDING DETERMINATION OF THIRD-PARTY COVERAGE. PROVIDERS ARE TO COMPLETE INVESTIGATION OF AVAILABLE RESOURCES BEFORE SUBMITTING THE CLAIM TO THE DEPARTMENT FOR PAYMENT.

(2) IF THE RECIPIENT STATES HIS PRIVATE HEALTH INSURANCE HAS BEEN CANCELLED, HE SHOULD BE ADVISED TO CONTACT HIS COUNTY DEPARTMENT OF HUMAN SERVICES CASEWORKER TO CORRECT HIS CASE RECORD. IN SUCH CASES, THE PROVIDER MAY BILL MEDICAID DIRECTLY.

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